United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

March 19, 2024

The Honorable Denis R. McDonough
Secretary of Veterans Affairs
810 Vermont Ave NW
Washington, DC 20420

Dear Secretary McDonough,

The American people entrust VA's government and contracted employees with the protection and care of our nation's veterans and their families. When our government oversight partners disclose serious deficiencies in VA's ability to manage its workforce, VA leadership should provide an explanation and commit to own the shortcomings until they are rectified.

A report from the Department of Veterans Affairs' (VA's) Office of Inspector General (OIG) published on February 8, 2024 highlighted unacceptable risks that VA imposes on the health and safety of the veteran community by failing to screen employees for prior criminal activity and improper conduct.[1] As discussed in the report, these shortcomings recently enabled unvetted VA employees with prior criminal records of physical and sexual assault, terroristic threats, and financial fraud to leverage their VA employment to stalk, sexually harass, and assault new victims at VA facilities. Inexplicably, the report noted that five of the noncompliant VA contracts that OIG reviewed were for childcare services and "could have led to unvetted contractor employees working with children."[2]

Due to longstanding disagreements between the two offices responsible for personnel security, the VA OIG recommended the VA Deputy Secretary mediate to develop and publish necessary updates to employee screening policies and procedures. The Deputy Secretary responded that the Office of Human Resources and Administration/Operations, Security, and Preparedness (HRA/OSP) has established and communicated standardized contractor vetting processes and "various policies and clauses are continuously reviewed and updated in the normal course of business, as necessary."[3] The American people expect more from its government leaders than a bureaucratic nothing-to-see-here dismissal of a well-founded and critically necessary recommendation by VA's Inspector General.

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[1] OIG Report, Noncompliance with Contractor Employee Vetting Requirements Exposes VA to Risk (Feb. 08, 2024), https://www.vaoig.gov/sites/default/files/reports/2024-02/vaoig-21-03255-02_1.pdf
[2] *Id.* at 12
[3] *Id.* at 35

According to the VA OIG, "VA's five directives and handbooks that set requirements for vetting contractor employees are outdated, conflicting, and include inaccurate roles and responsibilities."[4] A Government Accountability Office (GAO) audit provided to the Department just one month before, in January 2024, similarly found that "VA guidance does not provide directions for how to plan and conduct oversight of these contracts" and that "VA has yet to strategically plan its workforce to ensure sufficient personnel are available to provide heightened management attention."[5]

The employee screening problem is not new and it is not limited to the Department's more than 40,000 contract employees with VA credentials. It is well documented that the issue also extends to the Veterans Health Administration's (VHA's) more than 400,000 employee workforce as well.

In 2017, a Kansas jury convicted a former Eisenhower VA Medical Center physician assistant in Leavenworth, Kansas for sexual crimes against his patients, including aggravated criminal sodomy and aggravated sexual battery.[6] The VA employed the perpetrator even after his disclosure of a prior conviction in a state physician assistant license application and prior charges for lewd behavior. [7] Years later, VA settled lawsuits with more than 80 sexual assault victims of the now rightfully imprisoned former VA physician assistant.[8] According to a federal judge, "the Leavenworth VA wholly failed" to comply with a policy on reporting and tracking allegations of sexual misconduct and should have "fairly foreseen" the wrongful conduct.[9]

VA leaders committed to me then, and have repeatedly committed to the VA OIG, GAO, and Congress ever since, to address the severe shortcomings in VA's employee screening processes. While necessary oversight of VA in this critical space has increased, VA's leaders have failed to right the ship.

A March 2018 VA OIG audit of VHA's personnel suitability program found VA did not ensure background investigation requirements were completed when required at medical facilities nationwide.[10]

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[4] *Id.* at 13

[5] GAO Report, VA Acquisition Management: Oversight of Service Contracts Needing Heightened Management Attention Could Be Improved (Jan. 25, 2024), https://www.gao.gov/assets/d24106312.pdf

[6] Tim Carpenter, Kansas jury convicts former VA physician assistant from Horton of 5 sex-related crimes, The Topeka Capital-Journal, Aug. 29, 2017, https://www.cjonline.com/story/news/politics/state/2017/08/30/kansas-jury-convicts-former-va-physician-assistant-horton-5/16531005007/

[7] Shannon O'Brien, VA settles nearly $7 million lawsuit with 82 victims of Leavenworth physician's assistant, Fox4 Kansas City, Dec. 10, 2019, https://fox4kc.com/news/va-settles-nearly-7-million-lawsuit-with-82-victims-of-leavenworth-physicians-assistant/

[8] Jonathan Shorman, Bryan Lowry, 'Horrifying' abuse scandal still haunts Leavenworth VA Center; Moran floats reforms, The Wichita Eagle, April 12, 2021, https://www.kansas.com/news/politics-government/article250551844.html

[9] Dan Margolies, Government Ordered To Pay Damages To Two Veterans Abused At The Leavenworth VA, KCUR/National Public Radio in Kansas City, November 2, 2020, https://www.kcur.org/news/2020-11-02/government-ordered-to-pay-damages-to-two-veterans-abused-at-the-leavenworth-va

[10] VA OIG Report, Audit of the Personnel Suitability Program (Mar. 26, 2018), https://www.vaoig.gov/sites/default/files/reports/2018-03/VAOIG-17-00753-78.pdf

An OIG inspection in 2021 found timely adjudication of a VA provider's background investigation in Clarksburg, West Virginia, could have revealed concerning conduct identified in a prior non-VA position and prevented the provider's subsequent murder of seven veteran patients.[11] In a September 2023 OIG report entitled, "VA's Governance of its Personnel Suitability Program for Medical Facilities Continues to Need Improvement," the OIG determined that "VHA personnel suitability staff still did not always initiate or adjudicate background investigations in a timely manner and did not maintain records as required."[12]

Last July, at the Kansas City VA Medical Center, it is reported that a male VA employee was caught on camera in a facility parking lot aggressively pushing a veteran patient's female partner to the ground, after the veteran tried to help clear a pickup truck from blocking an ambulance.[13] *Was there a background check conducted before VA hired that employee?* The answer should be easy, especially as we have been assured by VA leadership that "various policies and clauses are continuously reviewed and updated as necessary." Unfortunately, government watchdogs have continuously exposed unacceptable risks to the veteran community generated by failures in VA's employee screening processes.

Key deficiencies flagged in the September 2023 OIG report had been previously identified in the March 2018 OIG audit. The investigations found that unvetted staff were in positions to provide direct patient care. While requirements existed to conduct program reviews of the personnel suitability function, the September 2023 report revealed that "the Office of Human Resources and Administration/Operations, Security, and Preparedness (HRA/OSP) ***suspended*** required inspections of the program."[14]

In other words, HRA/OSP, the same office that VA leadership asserted is in command of establishing and communicating standardized vetting processes and updating various policies as necessary, actually halted oversight of those key functions during a period of critical need. To make matters worse, HRA/OSP is currently embroiled in scandal and leadership resignations following reports that the office leaders responsible for harassment prevention standards across the Department had been sexually harassing their own subordinates.[15]

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[11] VA OIG Report, Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia (May 11, 2021), https://www.vaoig.gov/sites/default/files/reports/2021-05/VAOIG-20-03593-140.pdf

[12] VA OIG Report, VA's Governance of Its Personnel Suitability Program for Medical Facilities Continues to Need Improvement (Sep. 21, 2023), https://www.vaoig.gov/sites/default/files/reports/2024-02/VAOIG-21-03718-189.pdf

[13] Linda Wager, Camera shows Kansas City couple's assault incident at VA Medical Center, FOX 4 KANSAS CITY, Feb. 22, 2023, https://fox4kc.com/news/problem-solvers/camera-shows-kansas-city-couples-assault-incident-at-va-medical-center/

[14] VA OIG Report, VA's Governance of Its Personnel Suitability Program for Medical Facilities Continues to Need Improvement (Sep. 21, 2023), https://www.vaoig.gov/sites/default/files/reports/2024-02/VAOIG-21-03718-189.pdf

[15] Jory Heckman, VA sexual harassment investigation recommends firing, recouping bonuses from supervisors, Federal News Network, February 14, 2024, https://federalnewsnetwork.com/workforce/2024/02/va-sexual-harassment-investigation-recommends-firing-recouping-bonuses-from-supervisors/

In yet another oversight report flagging employee screening deficiencies allowed by the Department, a February 2023 GAO report entitled, "Action Needed to Address Persistent Control Weaknesses and Related Risks in Employee Screening Processes," GAO found 12,569 VHA employees with indications of controlled substance related criminal histories.[16] In a sample of these employees, GAO found that more than 15 percent had one or more controlled substance-related felony convictions, while four percent had not even had a background investigation completed.

The Drug Enforcement Administration requires employers such as VHA to apply for and receive employment waivers for prospective employees who have prior felonies related to controlled substances. GAO found that VA did not request waivers for 96% of the sample cohort of VA-employed felons that they reviewed. That finding in 2023 was somehow made possible even after a GAO report in February 2019 highlighted for VA that it "did not have policies regarding DEA employment waivers, and that this may affect its ability to prevent the diversion of controlled substances in its medical facilities."[17, 18]

Just as VA should not employ workers with unacceptable prior criminal activity and improper conduct, the American taxpayer does not fund VA to employ unqualified health care providers to provide direct care to our veterans.

In the February 2019 GAO report entitled, "Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care," GAO found that staff in at least five facilities responsible for credentialing and hiring "were unaware of the policy regarding hiring a provider whose license had been revoked or surrendered for professional misconduct or incompetence, or for providing substandard care. As a result, these five VHA facilities hired or retained some providers who were ineligible."[19]

Further, GAO identified cases when hiring officials did not respond to adverse actions that were present in a readily available national database "because they were unaware of or overlooked the disqualifying information."[20] Examples of providers hired by VHA included those whose medical licenses had been previously revoked for patient neglect and substandard care, drug diversion, fraudulent license, health-care fraud and money laundering, substance abuse, incapacity in the practice of medicine, hazardous negligence, drunk-driving, and patient abuse. The report stated that VHA completed a onetime review of all licensed providers beginning in December 2017, and removed 11 providers who did not meet licensure requirements. However, VHA officials noted the onetime review was "labor intensive" and, "these types of reviews are not routinely conducted."

VA has also been cited for failing to disclose to state licensing boards the professional misconduct and substandard care conducted by VA providers while employed by VA.

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[16] GAO Report, VHA: Action Needed to Address Persistent Control Weaknesses and Related Risks in Employee Screening Processes (Feb. 23, 2023), https://www.gao.gov/assets/gao-23-104296.pdf
[17] *Id.* at 2
[18] GAO Report, VHA: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care (Feb. 28, 2019), https://www.gao.gov/assets/d196.pdf
[19] *Id.*
[20] *Id.* at 18

An April 2022 OIG report found "widespread noncompliance with [state licensing board] SLB and [National Practitioner Data Bank] NPDB reporting processes applied by facilities to healthcare professionals whose conduct or competence led to separation from employment."[21] As the OIG noted, "failure to comply with these reporting processes leaves SLBs and recipients of NPDB information unaware of a healthcare professional's practice deficiencies and ultimately violates an important VA commitment to protect the health of veterans and the public."[22]

As evidence of the real-life impact resulting from VA's allowance of these persistent oversight deficiencies, in a report published on February 6, 2024, the OIG found that a Chief of Staff had practiced without privileges and in violation of VA policy when providing pregnancy care for a patient.[23] OIG found that the provider placed the patient and her baby at risk by failing to follow evidence-based clinical standards. Professional practice evaluations that could have caught this unacceptable conduct were not completed, nor did the Facility Director initiate or complete state licensing board reporting on three occasions when reportable deficiencies were identified. This lapse in state licensing board reporting enabled the provider to continue to practice in the private sector and, for a significant period following the provider's departure from VA, may have allowed the provider to serve veterans as a non-VA provider in VA's community care network.

As OIG and GAO have clearly articulated time and time again, through inadequate screening processes for employees ranging from direct care providers, to security personnel, to contracted child care providers, VA is placing the health and safety of veterans, their families, the public, and your workforce at unacceptable risk.

By April 19, please provide me with your comprehensive plan, to include any legislative needs, to make certain VA's workforce will be screened and held to the highest professional standards. In preparing the plan, I ask that you not defer responsibility to a subordinate office whose policies have led to the oversight reports referenced above. The numerous reports referenced above clearly demonstrate that your personal leadership is necessary to ensure the safety and well-being of veterans, the American public as a whole, and VA's workforce.

Sincerely,

Jerry Moran
Ranking Member

cc: Michael Missal, Inspector General, Department of Veterans Affairs
Gene Dodaro, Comptroller General, Government Accountability Office

[21] VA OIG Report, Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities (Apr. 7, 2022), https://www.vaoig.gov/sites/default/files/reports/2022-04/VAOIG-20-00827-126.pdf
[22] *Id.* at i
[23] VA OIG Report, Chief of Staff's Provision of Care Without Privileges, Quality of Care Deficiencies, and Leaders' Failures at the Montana VA Health Care System in Helena (Feb. 7, 2024), https://www.vaoig.gov/sites/default/files/reports/2024-02/vaoig-22-02975-70_4.pdf